CPS INSURANCE SERVICES

QUICK QUOTE FOR ULCERATIVE COLITIS & CROHN'S DISEASE

CLIENT: NAME _____ / ☐ M ☐F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMT. REQUESTED $ _____ / MAX. ANNUAL PREMIUM $ _____ / TYPE OF INS. ☐ UL ☐TERM YRS. LVL _____

TOBACCO USE ☐ NO ☐YES, TYPE _____ / REPLACEMENT ☐YES ☐NO / CURRENT ANN. PREM. $ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION _____ / MARITAL STATUS ☐ SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED

FAMILY HISTORY –
AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____

IF ANY DECEASED, PROVIDE RELATION, AGE AND CAUSE OF DEATH _____

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH CANCER, DIABETES OR HEART DISEASE PRIOR TO AGE 60? IF YES, PROVIDE RELATION, ILLNESS AND AGE OF ONSET_____

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK? ☐ NO ☐YES, DETAILS_ _____

DATE OF LAST MEDICAL CHECKUP _____ RESULTS _____

DATE OF LAST RESTING EKG _____ RESULTS_____

LAST BLOOD PRESSURE READING (EXAMPLE 140/80) _____/ ARE YOU TREATED FOR BLOOD PRESSURE? ☐ NO ☐YES

LAST TOTAL CHOLESTEROL READING AND HDL READING _____/ARE YOU TREATED FOR CHOLESTEROL? ☐ NO ☐YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION _____ FAX _____

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1. PLEASE NOTE TYPE OF INFLAMMATORY BOWEL DISEASE :

☐ CHRONIC ULCERATIVE COLITIS
☐ CHRONIC PROCTITIS
☐ CROHN'S DISEASE

2. PLEASE LIST DATE OF ONSET _____

3. PLEASE NOTE SEVERITY:

☐ MILD (UP TO 4 WEEKS DURATION, MAXIMUM 1 ATTACK PER YEAR)
☐ MODERATE (4 TO 6 WEEKS DURATION, 2 ATTACKSPER YEAR)
☐ SEVERE (OVER 6 WEEKS DURATION, 3 OR MORE ATTACKS PER YEAR)

4. PLEASE NOTE LOCATION(S) OF ULCERATIVE COLITIS:

☐ LARGE COLON
☐ SMALL BOWEL
☐ RECTUM ONLY (PROCTITIS)

5. DATE OF LAST ATTACK: _____

6. DATE OF LAST COLONOSCOPY AND RESULTS:

_____

_____

7. PLEASE DETAIL TREATMENT INVOLVED (CHECK AND DETAIL ALL THAT APPLY):

☐ MEDICATION, TYPE AND DOSAGE _____
☐ RESECTION WITH TOTAL COLECTOMY, DATE _____
☐ RESECTION WITH PARTIAL COLECTOMY, DATE _____
☐ SURGERY (IF OTHER), TYPE & DATE_____
☐ HOSPITALIZATION, DATE _____

8. PLEASE NOTE ALL OTHER RELATED COMPLICATIONS OR IMPAIRMENTS (CHECK ALL THAT APPLY):

☐ LIVER DISORDER OR ELEVATED LIVER FUNCTION TESTS; PROVIDE DETAILS BELOW IF CHECKED

AST_____ALT_____ GGTP_____ ALK PHOS _____

☐ ANEMIA
☐ GASTROINTESTINAL BLEEDING
☐ TRANSFUSIONS
☐ ARTHRTIS

9. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDICATIONS AND VITAMINS TAKEN:

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